Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
LARRY ECKARDT DC

Respondent Name
CHEROKEE INSURANCE COMPANY

MFDR Tracking Number
M4-14-3268-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
JUNE 30, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAM CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS ACCORDING TO THE MDR NEWSLETTER PROVIDED AN ADDITIONAL $150.00 IS DUE AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 8, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2013	Impairment Rating Evaluation of a Musculoskeletal Body Area	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out fee guidelines for Worker's Compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 1 – The amount paid reflects a fee schedule reduction.
- 2 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the total allowable amount for the impairment rating of the spine?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involves a Designated Doctor Impairment Rating (IR) evaluation of the spine, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4)(C)(ii), which states that "The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area."

   The Division notes that the document titled *Medical Dispute Resolution Newsletter, No:4, March 2005* submitted by the requestor in support of its request is not applicable to the services in dispute. This article titled *Billing and Reimbursement for an Impairment Rating: ROM vs. DRE* discusses former §134.202, which is not applicable to the disputed service. The applicable rule is, as stated above, 28 Texas Administrative Code §134.204 adopted to be effective March 1, 2008, 33 TexReg 364.

2. According to the explanation of benefits and the respondent's position statement, the total of $150 was reimbursed by the carrier for the IR of the spine. The carrier alleges that this amount was appropriately calculated based upon §134.204(j)(4)(C)(ii) (I). The requestor disagrees. In its position, the requestor argues that the carrier should have allowed a total of $300 for the impairment rating of the spine because it asked for reimbursement based upon §134.204(j)(4)(C)(ii) **(II)(-a-) [emphasis added]**. In order for the requestor to be reimbursed pursuant to rule §134.204(j)(4)(C)(ii)(II)(-a-), the health care provider, in this case, was required to perform a full physical evaluation with range of motion of the spine. Review of the submitted documentation finds that the spine was rated using a full physical evaluation and range of motion. The Division concludes that the impairment rating of the spine is allowed at $300 in accordance with the requirements of §134.204(j)(4)(C)(ii)(II)(-a-).

3. The division concludes that the total allowable for the impairment rating of the spine is $300. The respondent issued payment in the amount of $150 for the IR of the spine. Based upon the documentation submitted, additional reimbursement in the amount of $150 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 7, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.